California Newborn Hearing Screening Program
Diagnostic Audiologic Evaluation Reporting Form

Please complete this form and Fax to 925-947-4956 or 925-947-4957 or Mail to the Bay Area/Northern California Hearing Coordination Center, 3480 Buskirk Avenue, Suite 125, Pleasant Hill, CA 94523, within seven days of the child's diagnostic Audiologic Evaluation. DO NOT attach waveforms, OAE printout, audiograms or reports. **If the family does not appear for the scheduled appointment and you have difficulty in rescheduling the outpatient hearing screening, please contact the Hearing Coordination Center at 925-941-7933.**

Infant's Name: _____ Date of Birth: _____ Date of Eval.: _____

AKA: _____ Gender: ☐ F ☐ M Medical Record No.: _____

Birth Hospital: _____ ☐ WBN ☐ NICU

Primary Care Provider (PCP): _____ Phone: _____

Parent or Legal Guardian: _____ Phone: _____

Address: _____ Zip: _____

Test Results: Indicate all components that apply. **Diagnostic evaluations should be completed as per the California Infant Audiology Assessment Guidelines and the Joint Committee on Infant Hearing Year 2000 Position Statement.**

Test Results		RIGHT	LEFT
	Average/Estimated Hearing Level (500-4kHz)	☐ Normal 0-20 dB ☐ Mild 21-40 dB ☐ Moderate 41-70 dB ☐ Severe 71-90 dB ☐ Profound 91+ dB	☐ Normal 0-20 dB ☐ Mild 21-40 dB ☐ Moderate 41-70 dB ☐ Severe 71-90 dB ☐ Profound 91+ dB
	Type of Hearing Loss *Leave blank if hearing is normal*	☐ SNHL ☐ CHL ☐ permanent ☐ transient ☐ Mixed ☐ Auditory Neuropathy/Dys-synchrony ☐ Undetermined/testing not completed next appt❖:_____	☐ SNHL ☐ CHL ☐ permanent ☐ transient ☐ Mixed ☐ Auditory Neuropathy/Dys-synchrony ☐ Undetermined/testing not completed next appt❖:_____

❖ Should be scheduled ASAP, program goals include diagnosis of hearing loss by 3 months of age and entry into Early Intervention services by 6 months.

Discussion: _____

_____

Amplification Status: ☐Not Required ☐Not Recommended ☐Recommended ☐Refused

Explain: _____

_____

Other Diagnoses Related to Hearing Loss: _____

_____

Plan/Follow-up appt.: _____

Referral to ENT: Date: _____ **Physician:** _____ **Phone:** _____

Referral to CCS: Yes: Date: _____ ☐ Application ☐Request for Service ☐ County: _____

No: Already known to CCS_____ County: _____

Referral to Early Start (1-866-505-9388): Date: _____ Hearing loss information given to parent/guardian: ☐Yes ☐No

Parent/Guardian refused services: Yes Refused by: _____ Date: _____

Parent/Guardian Contact Attempts: Document at least 3 attempts to contact the family.

1. Contact: ☐ Mail ☐ Phone ☐ Fax Date_____ Result: _____
2. Contact: ☐ Mail ☐ Phone ☐ Fax Date_____ Result: _____
3. Contact: ☐ Mail ☐ Phone ☐ Fax Date_____ Result: _____

Audiology Facility: _____ Phone: _____ Fax: _____

Audiologist Name (Print) _____ Signature_____ Lic.# _____

Please complete all relevant information. Incomplete forms will be returned.

This information is to be provided pursuant to Section 124119 of the California Health and Safety Code that requires you to report the results of audiological follow-up services provided through the California Newborn Hearing Screening Program.